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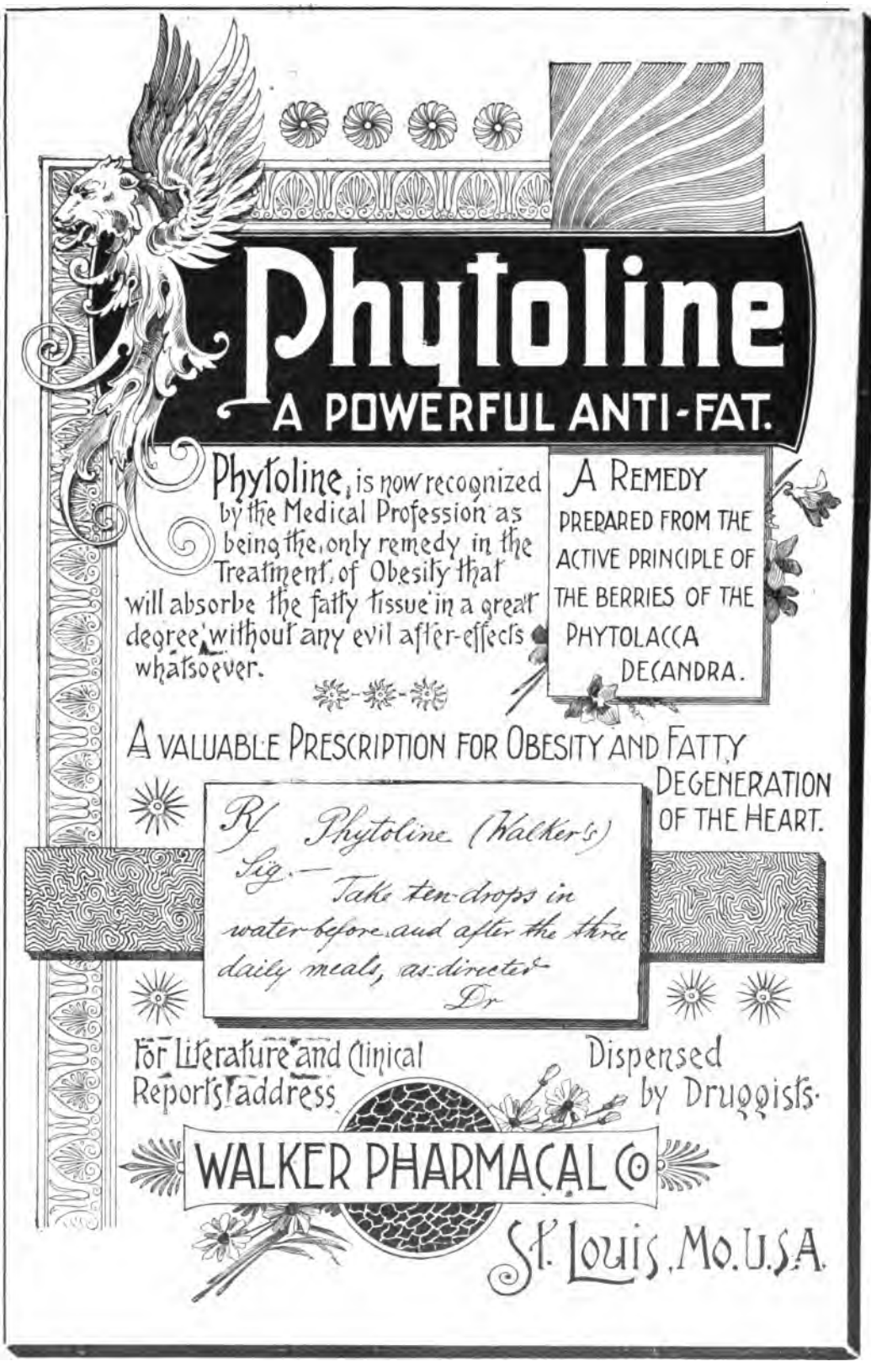
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The Medical Fortnightly

BY BRANSFORD LEWIS, M. D.

Lecturer on Genito-Urinary Surgery and Venereal Diseases, Missouri Medical College; Consultant Genito-Urinary Surgery to the Missouri Pacific Hospital, the City Hospital, the Female Hospital, and to St. Mary's Infirmary, Saint Louis; member of the American Medical Association, the National Association of Railway Surgeons, and the American Association of Genito-Urinary Surgeons.

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$2.00 Per Year. : ST. LOUIS—CHICAGO, AUGUST 15, 1893. : Vol. IV, No. 4

Original Department.

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Some Further Experience in the Dilatation of the Fallopian Tube.

BY WALTER B. DORSETT, M. D.,

ST. LOUIS.

Professor of Diseases of Women and Clinical Gynecology, St. Louis College of Physicians and Surgeons Gynecologist to St. Louis Deaknessenhaus; Consulting Gynecologist to City and Female Hospitals; Ex-President St. Louis Medical Society; Secretary of St. Louis Obstetrical and Gynecological Society; Member American Association of Obstetricians and Gynecologists; Member of St. Louis Surgical Society.

Abstracted from a Paper Read before the Missouri State Medical Society, May, 1893.

UNDER the title of "The Location of Tubal Abscess as an Indication for its Treatment," I read a paper before the St. Louis Surgical Society on June 15th, 1892, in which I deprecated the tendency on the part of some members of the profession to laparotomize every case of pyosalpinx, and made a plea for a more conservative method of treating cases of abscess of the tube when located in proximity to the uterine horn.

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In presenting this paper I wish to be stringent upon my professional brethren who do much abdominal surgery upon the female. I claim that in certain inflammatory troubles of the tubes it is not necessary to open the belly and take out the tubes and ovaries. There are, as we all must admit, cases of abscess located near the uterine end of the tube in which the contents have not leaked into the general peritoneal cavity, so also there are cases of hydro- and hematosalpinx in which the dilatation of the tube by its contents has not reached the fimbriated extremity. *These* are the cases to which I wish to draw attention and submit a treatment based upon anatomical grounds, upon the observation of many cases, fortified by a number of cures, the histories of which I will detail in this paper.

I have opened the abdomen and extirpated the tubes and ovaries a number of times, but as my experience has advanced, so have my doubts increased as to whether my practice was, in every case, justifiable; and while I have every reason to believe that the results of my laparotomies compare favorably with other gynecologists, I am not prepared to give you as large a percentage of cures as I would like. And while the utmost precautions may be practiced in the way of antiseptics, we all have to admit that we now and then lose patients who ought not to have died. Who can say that this or that case, although seemingly a favorable one, will not die from shock, from persistent vomiting, from peritonitis, or that this or that case will not have a fecal fistula, or a ventral hernia, or that a ligature here or there may not slip and the patient bleed to death?

Then again, when once the abdomen is opened, what a tendency there is to take out both ovaries, when perhaps only one tube or, perchance, one ovary is the site of the trouble. The laparotomist will possibly give as his excuse for taking out both ovaries, that Dr. P. or Dr. G. always advises the extirpation of both ovaries when only one is involved in a gonorrheal or puerperal inflammation. In the justification of such teaching it may be said that the non-extirpation of a gonorrheal tube maintains a constant source of danger, and that such cases never recover. I must say I cannot, in the light of personal experience, subscribe to such a declaration. It does not stand to reason that the tube should be extirpated because it once contained pus, any more than that any portion of the genital tract in the male should be extirpated because it once was the site of a previous specific catarrh.

I do not wish to be understood as being opposed to the extirpation of pus-tubes and ovaries affected with suppurative troubles, when such a course is the only one left open to follow, but I do think that many tubes and ovaries can be treated in a different way.

The conclusions I have arrived at are based upon observation of cases under my care while occupying the position of Superintendent of the St. Louis Female Hospital, and extended over a period of nearly five years. These observations are as follows:

1st. I have noticed that in tying off diseased tubes in cases of tubal abscess that was located near the uterine horn, that the ligature would frequently cut through the tube, and that occasionally several attempts

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would have to be made before the ligation could be done, and then it was not done satisfactorily.

2d. That tubal abscesses, whether they were located near the uterine end or not, were primarily near the uterus.

3rd. That gonorrheal tubal troubles were more frequent in cases that had shown no symptoms of a previous chronic endometritis.

4th. That gonorrheal salpingitis frequently existed without a corporeal inflammation of the uterus, and consequently, we do not find, in these cases, a patulous os, but, on the contrary, the cervix is firm and the cervical canal is not easily dilated; therefore, there is no provision furnished by nature to drain the septic cavity, and as a natural order of things, the virus, in its proliferation, travels upward and into the tube, instead of downward, as would be the case if the os were patulous.

5th. In my daily bi-manual examinations of pelvic cases, I have frequently felt inflammatory swellings located near the uterine horn, and on several occasions I have been enabled to knead pus into the uterus with my index finger in such quantities that it would flow out of the cervix uteri into the vagina, demonstrating the fact that tubal abscesses do sometimes voluntarily open into the uterus.

To aid and assist Nature in all things pertaining to the cure of diseases, is not only the duty of the physician, but in the practice of medicine and surgery, it is the only rational thing to do; and when she points out the way, and we fail to follow, we are sure to go wrong.

For the purpose of better understanding the rationale of the treatment pursued in these cases, let us for a moment consider the anatomy of the tube.

It has three coats—an external, serous; middle, muscular; and internal, mucous. For our purpose, the muscular and serous, only, need be considered. The diameter of the tube, we know, is not uniform throughout the entire length. At the uterine end the diameter is 0.13 inch; in the middle, 0.23 inch; while at the abdominal extremity it is 0.31 inch. Fallopius has properly compared it to a trumpet in shape and general contour, the uterine end representing the mouthpiece, the intermediate portion between this and the pavilion representing the body of the instrument, and the pavilion the expanded portion, or flange.

The muscular coat, we are told, consists of two layers—an external, composed of longitudinal fibres which are formed from the prolongation of the fibres of the uterus; and an internal layer of circular fibres beginning at the uterus, where it forms a sphincter and is continued outward toward the abdominal end.

The muscular fibres of the uterus which here concern us, are the following: 1. The external layer of the fundus, arranged transversely as a plane on the anterior, superior and posterior surfaces of the upper uterine segment, and converging at the origin of the tubes. The middle layer, arranged in an irregular manner, does not materially affect the consideration of the subject. 2. The internal or deep coat, consisting of circular fibres arranged in the form of two hollow cones, the apices of which surround the orifices of the tube, so we may consider that we have here two cones, the

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apices of which are in apposition, the one being the fallopian tube and the other the one-half of the uterus.

Now suppose we should take a hollow cone, constructed, for example, of paper or pasteboard, and should systematically pack in to the apex of this cone any soft material until the packing is firm, would it not have a tendency to dilate the apex? Now, in these cases we do exactly the same thing, and by allowing this packing to remain in for from twenty-four to forty-eight hours, there is produced a muscle-tire of exhaustion, and relaxation necessarily takes place, and a communication between the abscess cavity and the cavity of the uterus is established, followed immediately by a profuse flow of pus. In following this procedure, I have noticed that in several cases I have found, on exposing the cervix, that the os was small and tight and that it was only with some difficulty that I could get any considerable amount of gauze past the internal os, but on the second day the uterus presented an entirely different aspect; it was always soft and easily dilated, so that the uterus could be easily packed to the fundus and into the horn, and on the third day, when the gauze was withdrawn, it was followed by a flow of pus.

Now as to the technique of the operation: When once the diagnosis is established that we have to deal with an abscess of the tube, located near either horn of the uterus, or that we have a collection of aqueous material or blood filling the tube, and that only the sphincter of the tube prevents its discharge into the uterus, the patient is prepared in the same manner and with as great care as she would be should we intend to make a laparotomy.

The evening before the operation the bowels are evacuated and a hot, bichloride vaginal douche is given, 1-4000. The day and hour decided upon, the patient is placed upon the table in a Sim's position, the perineum is retracted with the short blade of a Sim's speculum and the uterus drawn down with a vulcellum forceps. The uterine dilator of Peasely is introduced and the neck slowly dilated to the extent of one inch, if possible; a small sharp curette is then introduced and the cavity thoroughly scraped out. A uterine irrigator is then introduced and the cavity is washed out with a solution of bichloride of mercury of the strength of 1-4000. Narrow strips of 10 per cent iodoform gauze are then systematically packed into the uterine cavity, a constant effort being made to pack the side next to the inflammatory swelling tighter than elsewhere, or, in other words, the apex of the uterine cone is packed as tight as possible without using too much force, for should the applicator slip off the gauze, the uterine wall might be punctured.

Enough gauze is used to fill the uterus and about one inch of the end of these strips is left hanging out of the cervix. The vagina is then packed moderately tight with bichloride or iodoform gauze and the patient put to bed and, if necessary, given a hypodermic injection of morphine; this, however, in the majority of cases has not been necessary, as very little pain follows the treatment.

The instruments used are a Sim's speculum, a uterine irrigator and a small whale-bone applicator with which the packing is done. There has

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been devised a uterine-speculum as well as a uterine dressing-forceps for packing the uterus, but these instruments are unnecessary and useless.

The end of the narrow strip of gauze is laid over the os and the point of the whale-bone applicator pushes the gauze into the uterine cavity as far toward the uterine horn as possible at one effort. Being smoothly polished it is easily withdrawn and does not drag back the gauze, as does the uterine dressing-forceps of Polk. Within twenty-four to forty-eight hours the gauze is removed from the vagina and uterus, and the uterus is washed out and repacked as before. It is seldom necessary to repeat this operation more than twice to effect a thorough evacuation of the abscess. The patient is kept in bed from eight to ten days and then allowed to go about her usual duties. I have, up to the present time, treated in this manner twelve cases of tubal abscess and one of hematosalpinx. Of the twelve abscess cases, three were bilateral and nine were unilateral. Five were of gonorrheal origin. Four were puerperal and one was, in all probability, caused by unclean instruments in the hands of a physician who was treating the patient for a supposed case of endometritis. In two the origin of the trouble could not be fully determined.

* * * * * *

In the discussion of this subject students of pathology may say that inasmuch as gonorrhea is a disease of the sub-mucosa as well as the superficial mucous membrane, when a narrow canal like the Fallopian tube is once the seat of an inflammation, such as would be produced by gonorrhea or infectious material from a necrotic placenta, irreparable damage has been done, and that an extirpation of the tubes alone will suffice to effect a cure. Again, it may be said that, remotely, menstruation will be interfered with after the changes incident to a high degree of inflammation has subsided, that strictures of the tubes will follow. In answer to this I will say that such troubles have not followed the cases delineated in this paper.

Of course the operation is limited in its sphere to only cases in which the inflammatory swelling is located near the uterine horn, and in which the tumor is found on bi-manual palpation to be continuous with the uterine body. Should a sulcus intervene between the tumor and the uterine body, it is then clearly a case for abdominal section. And should the inflammatory, and possibly fluctuating, tumor be in the cul de sac of Douglass, the very location of the tumor demonstrates the fact that either leakage has taken place and that in all probability the ovary is prolapsed and diseased as well, and that the case is one for vaginal retro-uterine puncture or abdominal section.

If the collateral symptoms and history should point towards a tubal abscess in a fleshy patient, where it would be impossible to clearly define the anatomical relations of the tumor by bi-manual palpation, I would first try dilatation before subjecting my patient to a laparotomy, everything else being equal. Of course there are cases in which urgent symptoms may arise and demand laparotomy at once. In such cases the patient should be accorded the benefit of the radical operation.

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The *time* for dilatation is when we are thoroughly certain that we have a pus-sac to deal with, and during the early inflammatory stages. Delays are dangerous, for by proliferation the pus may soon find its way into the abdominal cavity through a ruptured abscess wall or through the pavilion.

Every case is a law unto itself and should be treated accordingly, bearing in mind the fact that laparotomy is not demanded in every case.

Hallie B. Borsett

Consultants to the City Institutions.—The following resolutions were passed at the last meeting of the St. Louis Board of Health:

WHEREAS, In view of the indefiniteness and insufficiency of official information as to who has been appointed consultants to the different hospitals under city control and are now holding such positions, the terms of such appointments and the duties and obligations toward the city of those holding them, it is desirable that a clearer understanding in this regard be had, and some definite rule be followed in future; therefore be it

Resolved, That the Board of Health hereby reconsiders its action in this respect, and vacates and annuls all existing appointments of this kind. And be it further

Resolved, That the proper committee be instructed to prepare and submit to the Board a rule or plan to govern all such appointments in future.

The foregoing preamble and resolutions were adopted by the Board of Health on July 20 last, the object being to formulate a systematic plan by which appointments to the various institutions may be made in future.

DR. OTTO E. FORSTER.

NECROLOGIC.

Dr. P. Ten Eyck of Albany, New York, at the age of 91.

Dr. Samuel E. Munford, of Princeton, Indiana, of tuberculosis.

Dr. Henry Fisher, dentist, of 321 Forth Grand Avenue, died suddenly, August 1st.

Dr. James O'Rorke, one of the Board of the St. Vincent's Hospital, New York, July 30th.

Dr. Charles P. Strong, one of Boston's most esteemed surgeons. He was infected during an operation on a septic subject.

Dr. Israel, for many years assistant to Professor Virchow, of Berlin, and Extraordinary Professor in the Berlin University.

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The Medical Fortnightly

Tattooing of Corneal Cicatrices.—A New Instrument.

BY C. BARCK, M. D.,

SAINT LOUIS.

Read before the St. Louis Medical Society, May 20th, 1893.

IN going through the different text-books, I find that satisfactory instruction as to tattooing is given in none of them. The advice uniformly given is simply to dye the white spot or the whole whitish cornea, black. By this method the appearance is no doubt somewhat improved. But in cases of larger or complete leukomata, to which I mainly refer here, the effect thus produced anything but resembles a natural eye. Why? Because the most characteristic feature, the black pupil in the centre, is wanting. Can this be accomplished? Certainly. To attain it, it is necessary to color a round spot in the centre and leave an area around it unstained, so that the pupil shows by contrast. The periphery again is tattooed. But whilst the pupil is stained as intensely black as possible, the peripheral ring is not dyed so uniformly, more grained, so to speak, so as to resemble somewhat the iris. We might call it, therefore, the iris-ring. In the special instance the iris of the healthy eye is to be imitated as to the shade of color.

Whilst I have proceeded on this plan for years, I have always felt that there was something wanting to make the result a perfect one. Only an artist draughtsman is able to make the pupil and the inner borderline of the iris-ring absolute circles and parallel to one another. To do away with this difficulty, I had this little instrument constructed. It consists of two parallel cutting rings, one within the other. The inner one to mark off the pupillary space, the outer one to define the inner border of the iris-ring. The interspace corresponds, of course, to the unstained area.

A moderate pressure and slight rotatory movement suffices to produce the necessary impressions. These landmarks are to be stained at once, and will then remain visible and serve as a guide. The process of tattooing is then finished as outlined above.

I can recommend this little instrument and method, as by the sharp defining of limits and the contrast of coloring my results have become satisfactory from an artistic point of view.

INSTRUMENT.

Impression.

Coloring.

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The Medical Fortnightly

A Case of Malarial Hæmatura.

BY L. M. PERKINS, M. D.,

ST. LOUIS.

Read Before the St. Louis Medical Society, April 29th, 1893.

THE case I report this evening is one of intermittent hæmaturia, which has been rather persistent. The patient is a young man 22 years old, single, a traveling salesman. He is of healthy Irish parentage, and physically and mentally is above the average. Habits are good. The only disease of childhood he has had is measles. He has frequently had "chills and fever," but the attacks do not appear to have been very severe. In September of 1885 he had an attack of typhoid fever which was not very severe, for he returned to school in five or six weeks. In November *or* December of that year he had the first attack of hæmaturia. It was of an intermittent character, worse some days than others. It lasted about a week or ten days. He had a similar attack the following spring. Since then he has had one or more attacks every year, generally in the first half of the year. I saw him for the first time in August, 1891. I found him complaining of nothing but bloody urine. This attack was thought to have been brought on by some athletic sports. I saw him but once; enjoined rest, and prescribed digitalis and ergot. This attack lasted about four weeks, and appears not to have been very severe. The following February he had another attack, lasting a little more than a week. This he treated by a renewal of the medicines given the previous August. After this he was well for more than a year, to the beginning of his present attack, which began five weeks ago. He repeated his former medicine, but got no relief. A week later I saw him again. He appeared to be in splendid health, not having an ache or pain. His appetite was good and bowels regular. His pulse was 73, and there was only a slight elevation of temperature. There was no cause assigned for this attack. The urine, collected in separate vessels as voided, showed a daily change. In the morning and forenoon it was of a dark chocolate color, and deposited a thick, tarry sediment. The color gradually changed through the day, and in the evening was of a bright scarlet color, with but little sediment. I observed a few evening specimens that settled to a normal color, but usually they were much too red, as if charged with the coloring matter of the blood.

The urine was acid—1022, showed large quantities of albumen, but appeared to be about normal as regards other constituents. The microscope revealed large quantities of both red and white blood disks, in about the proper ratio. No casts of any kind were discovered, nor any epithelium, although a great number of specimens were examined.

The cause of this disease is certainly not clear. That it may come under the head of *intermittent hæmaturia*, or paroxysmal hæmoglobinuria, is possible, but the symptoms do not entirely tally with those described by Da Costa, as there is a large quantity of blood disks in the urine, and the attacks are not ushered in with a chill.

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It is by no means clear that it is a case of malarial hæmaturia, yet there is history of frequent attacks of chills and fever. Still at no time since the beginning of the present attack have I found his fever to be over 101°. He is now becoming somewhat paler than at first, and looks a little yellow, but only a trifle so. He has taken a variety of internal remedies, as gallic acid, lead acetate, digitalis, opium, ergot, and quinine, and he is neither better nor worse. That the blood may not come from the kidneys does not appear probable, for, voided in several different vessels, the appearance is the same in all. There are rarely any clots passed, but on one or two occasions there have been a few. Those which I examined in water appeared to be in shape and size as if cast in the ureters.

L. M. Perkins

Medical Society of the Missouri Valley.—The annual meeting of this society will be held in Council Bluffs, Iowa, September 21st (Thursday) and continue in session one day. Members contributing papers must send titles to the secretary prior to August 25th, so they can appear on the printed programme, mailed September 1st. Applications for membership can be sent to Dr. J. F. White, Council Bluffs, Iowa, with a fee of two dollars enclosed.

A Psychologic Battle.—The climax of a soul-stirring contest between two rising exponents of, as yet, undeveloped forces—Mr. Wallace, medium, and Mr. Tyndall, mind-reader—is thus thrillingly described by the psychologic reporter of the St. Louis *Republic:* "Then came the awful climax—a demon-like contest—a battle of eyes so fire-like, so masterful, so charmful, as of a glittering venomous snake that later it all but produced a riot. While Tyndall was hurrying to and fro, Jules Wallace on the stage left the crowd of newspaper men and walked to a chair next to the stage table. Here he sat down unobserved and alone. All eyes centered on the mind-reader moving to and fro before the stage. Then Wallace began to look, to gaze, to stare. His face straightened itself as if one of those professed trances was upon him. His arms straightened out, and he, too, nervously moved his slim fingers. Letting go, the drops of sweat came out on his forehead, and his face grew deathly pale and his eyes increased their vividness. It seemed as though all the fire of his being centered in those eyes. Like the diamond optics of the idol Juggernaut, as the straining, glittering magnets in the head of the cobra, shone those green-grey moons from his own forehead and the gaze fell constantly, cat-like, snake-like upon the face and movements of Tyndall. He was steady, crouching, straining—in reality he was charming, mesmerizing, hypnotizing the mind-reader. So he sat and stared and charmed, but few saw him." We should like to observe such an exhibition, but we would hesitate to come within the power of such an awful being.

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1006 OLIVE, ST. LOUIS. MASONIC TEMPLE, CHICAGO

The Medical Fortnightly

BY BRANSFORD LEWIS, M. D.,

CHICAGO, Masonic Temple. : : : 1006 Olive, ST. LOUIS.

FRANK P. NORBURY, M. D., Associate Editor.

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Editorial Department.

NEWS of Societies, and of interesting medical topics cordially invited. Write on one side of paper and be brief. Address books, subscriptions, and communications to THE MEDICAL FORTNIGHTLY, 1006 Olive Street, St. Louis.

HEART FAILURE.

While our Board of Health is doing such excellently good work in perfecting the sanitary regulations of the city, it is to be hoped that in due course it will turn its attention to the culpable negligence—it amounts to that—of the profession in using so frequently the term "heart failure" in filling out the certificate of death. There is no such term in the nomenclature of diseases as published by the Board, and we are earnestly requested to conform strictly to the names of the diseases as given, or where the meaning is too indefinite, to state the previous disorder, as dropsy from heart, or lung-disease, and to be precise as to the locality, as cancer of any organ, or inflammation of the cerebral or spinal meninges.

Heart failure as a disease *in esse* does not exist. The closest approach to it is in the so-called angina pectoris, as evidenced in a group of symptoms complicating different cardiac affections. The same symptoms are seen in anemia, hysteria and the psychoses, hence termed a neurosis, and because the sensory fibres of the heart come from the vagus, we have the designation neurosis of the vagus. The symptoms produce great distress and may result in death; it is believed, however, that even here, during life, physical signs of changes in the heart may be detected. The heart fails, therefore, because of previous disease, which can be sooner or later located by the skilled physician. It is our misfortune if we can not always explain the causes and termination of disease; but let us confess, where we must, our

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ignorance, and say that the terms we use are insignificant in meaning, or inadequate, though we make them presentable in the flowing robes of classical dress.

But if this too frequent use of the term heart-failure imply negligence on the part of the physician and reflect on his character as a scientific man, as often it may be used to conceal purposes of criminal intent. Instances are not infrequent where death has been the result of some criminal operation, and the dire event almost effectually concealed by this apparently innocuous term; and one can imagine that an obscure case of some infectious disease resulting fatally, may cause infinite disaster if allowed to appear in the mortuary reports as one of heart failure.

Our mortality statistics compare favorably so far as nomenclature is concerned, and even in every other point of view, with those of other cities. It is to our reputation as a scientific and moral professlon that we hold them so.

In the present instance, it is in the power of the Health Commissioner to reject all death certificates, designating as a cause of death, heart-failure.

WHAT ARE WE COMING TO?

If our telegraphic dispatches indicate a correct state of affairs, our State Boards of Health will not have time lagging on their hands very long. In the dailies of August 11th, were contained reports of yellow-fever cases, with two deaths, at Pensacola, Fla., a typhus fever case at Manhattan Beech, and two new cholera patients on the vessels held in quarantine at New York, with an additional death from the same affection at Swinburne Island. The American Surgeon representative at Antwerp, Belgium, also telegraphed that four new cases of cholera had been discovered in that city, and one death had occurred.

If epidemics of these diseases be added to the existing financial depression, the medical profession will have to bear the burden of increased work and decreased return.

Dr. Charles H. Stowell—who, by the way, needs no introduction to the reading portion of the American profession, prefers to introduce himself in his new capacity of Editor of *Food*, rather than to let his publishers apply the laudatory torch. He performs the feat gracefully, withal, illustrating Mark Twain's notion that 'twere better thus, in order that all the good things to be said about him should be said in an agreeable way, and by authority beyond dispute. It is presumed that Dr. Stowell will apply the same methods in the conduct of *Food* that made a success of the *National Medical Review;* that is, that he will write in such an interesting style as to compel the attention of the careless or perfunctory reader—and, possibly, make him subscribe, too.

Ovariotomy Without Anesthesia.—A case was reported at the Surgical Congress in Paris of a double ovariotomy on a patient with heart disease, where no chloroform was used. Local anesthesia along the line of incision of the abdominal wall was produced by the application of chloride of ethyl in powder. The woman recovered without trouble.—*Pacific Med. Jour.*

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FORTNIGHTLY GLEANINGS.

(BY HARRY WELLS, MO. MED. COLLEGE.)

The Empress of Germany has written a testimonial in favor of a baby food.

"*Daniel's Texas Medical Journal*" has changed its name, and henceforth will be known as the *Texas Medical Journal.*

When you are in doubt as to the diagnosis, examine the urine; when you think you know, examine the urine; when you are sure, examine the urine.—*Ex.*

The Emperor of Austria has accepted the office of Protector of the International Congress of Hygiene and Demography, which will be held in Buda Pesth in 1894.

Under the title of the College of Physicians and Surgeons, a new medical school has been started in Richmond, Va. The chairman of the faculty is Dr. Hunter McGuire. There will be a dental and pharmaceutical department.

The Texas legislature, at its last meeting, passed an act making it a penal offense for a physician to give a prescription for whiskey without first making an examination. The Texas legislature seems to be in the habit of breaking out periodically in this sort of style.

In London alone during 1892, diagnostic errors were responsible for the sending of between four and five hundred patients not suffering from contagious diseases, to contagious disease hospitals. This was recently acknowledged by the President of the Local Government Board to the House of Commons, and is a matter of record.

In view of the possible advent of cholera into this country, and of the necessity of studying its biological aspects, the directors of the Carnegie Laboratory in New York City, Alexander Smith and Frederic S. Dennis announce to all boards of health and to properly accredited men, the inauguration of a summer course of lectures on that subject, under the direction of Dr. Edward K. Dunham.

A meeting of medical editors attending the Pan-American Medical Congress will be held in Washington on September 4th, the day preceding the opening of the Congress. Particulars may be obtained from Dr. I. N. Love, of 3642 Lindell Avenue, St. Louis, who has been elected chairman of the committee on arrangements.

Health Commissioner Homan has demonstrated his originality in an invention, by means of which he is able at a glance to tell what parts of the city furnish the greatest number of dispensary and hospital cases. The device is a large map of the city, having pin holes in it, to correspond with the various streets; the ambulance driver, on bringing in a patient, sticks a pin into the hole corresponding to the portion of the city from which he got the patient. White pins are used for surgical cases and black ones for medical cases.

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Dr. Frank Glasgow and Dr. E. M. Senseny left for Denver on July 25th.

Patients taking large doses of iodide of potassium, especially those having an idiosyncrasy with respect to it, are very liable to edema of the larnyx.

Dr. H. C. Dalton, late superintendent of the City Hospital, has been made supervising medical director of the Knights of Honor. We congratulate both the Knights and Dr. Dalton for this very judicious selection.

Health Commissioner Homan appointed Dr. G. B. Perkins, Assistant Physician at the City Hospital, vice Dr. Miller transferred to the Poor House, and Dr. Arnold L. Tanssig, Assistant Physician at the Female Hospital, vice Dr. Perkins.

Dr. William Goodell, Professor of Gynecology in the Medical Department of the University of Pennsylvania, has resigned on account of the increasing demands upon him in his private practice. Dr. Chas. B. Penrose has been elected to fill the vacancy.

Assistant Surgeon A. E. Bradley, U. S. A., in a communication to the *New York Medical Journal*, disputes the allegation that tattooing is practiced among the enlisted men of the army to a great extent, while many of the soldiers bear upon their persons lewd and indelicate designs. They were placed there before they entered the service. Existing regulations pertaining to enlistment are adverse to the admission of any man disfigured with pictures of an unseemly character.

Medical Society discussions are sometimes reported in journals as they are "spoke;" here is an illustration, taken from the late issue of a contemporary: "Dr.—: Mr. Chairman, I merely wish to congratulate Dr.— on his very excellent paper. But I think that a discussion of the paper by a man who does very little in that branch of surgery would be very much out of place. I was delighted with the paper. It was an excellent paper. It was to the point, and more than that he covered the whole field, and he covered it from a sensible standpoint. It is the view which I would take of that subject, and in place of commenting on it I only think it my duty to congratulate the doctor upon his paper. The Chairman: Is there any further discussion upon this paper?" We hope that the paper "covered the field" better than the discussion.

We desire to call the attention of Delegates and Doctors going to the Pan-American Medical Congress to be held at Washington, D. C., Sept. 5th to 8th, inclusive, to the fact that the Big Four Route, in connection with the Chesapeake & Ohio, is the recognized line from St. Louis to Washington. No rates have as yet been announced for this meeting, but rates via Big Four and Chesapeake & Ohio will be as low as any line, and will positively not be more than one and one-third fare for the round trip. The one way rates are as follows: from St. Louis, $19.25; Chicago, $17.50; Cincinnati, $14.00; Indianapolis, $16.00; Louisville, $16.00. See next issue of this magazine for full information. Tickets will be on sale at Big Four Ticket Office, Cor. Broadway & Chestnut Sts., and Union Depot.

W. F. SNYDER, General Western Agent, St. Louis, Mo.

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The Reviewer's Table.

Books, pamphlets, instruments, etc., for this department, should be sent to the Editor, 1006 Olive street, St. Louis

A TEXT-BOOK OF NURSING, for the use of Training Schools, Families and Private Students. Compiled by Clara S. Weeks-Shaw. Second Edition Revised, Enlarged and Illustrated. New York: D. Appleton & Co. 1892. Pp. 387.

¶ The recent efforts to improve and elevate the art of nursing, as shown by the multiplication of training schools throughout the country for its study and practice, are recognized by all as constitutiug one of the most truly beneficent movements of the age. The present is a practical and handy little volume, full of instructive material for candidates for such a life-work. It contains chapters on the Sick-Room and Hospital Ward; Bed-Sores and Irregularities of the Circulatory System; Medical and Surgical Nursing; Emergency Treatment of Hemorrhage, etc., and a Vocabulary. For the purpose intended it is thoroughly commendable.

A TEXT-BOOK ON THE THEORY AND PRACTICE OF MEDICINE; By American Teachers. Edited by William Pepper, M. D., LL. D., Provost and Professor of the Theory and Practice of Medicine and of Clinical Medicine in the University of Pennsylvania. For sale by subscription only. Price per volume, Cloth, $5; Sheep, $6; Half Russia, $7. W. B. Saunders, Publisher, 913 Walnut Street, Philadelphia, Pa.

¶ Based on the same admirable endeavor to secure an exposition of the present status of American teachings of the most advanced and reliable sort as attained in the now famous American Text-Book of Surgery, Mr. Saunders has secured the co-operation of a number of eminent American teachers in medicine, and this is the outcome of the joint work. Volume II, which will complete the edition, has yet to appear. A feature that makes itself evident in the work—and one that will probably meet with the approval of the more studious portion of the profession—is that it does not appear to have been written so much for the ungraduated student as for him who, already conversant with the elements and principles of the practice of medicine, desires to learn the results of the deeper researches in etymology, diagnosis, prognosis and treatment, attained and described by modern investigators. The scope of the work is, therefore, great, and it is surprising that two volumes have been found capable of holding its erudite contents. The authors participating, and subjects embraced, are as follows: Hygiene, J. S. Billings, M. D.; Kidneys and Lungs, Francis Delafield, M. D.; Peritoneum, Liver, and Pancreas, R. H. Fitz, M. D.; Urine (Chemistry and Microscopy), James W. Holland, M. D.; Heart, Aorta, Arteries and Veins, E. G. Janeway, M. D.; Diathetic Diseases (Rheumatism, Rheumatoid Arthritis, Gout, Lithæmia, and Diabetes), Henry M. Lyman, M. D.; Blood and Spleen, William Osler, M. D.; Fevers (Ephemèral, Simple, Continued, Typhus, Typhoid, Epidemic Cerebro-Spinal Meningitis, and Relapsing), Pharynx, Œsophagus, Stomach and Intestines (Including Intestinal Parasites), William Pepper, M. D.; Tuberculosis, Scrofula, Syphilis, Diphtheria, Erysipelas, Malaria, W. Gilman Thompson, M. D.; Inflammation, Embolism, Thrombosis, Fever and Bacteriology, W. H. Welch, M. D.; Scarlatina, Measles, Rotheln, Variola, Varioloid, Vaccinia, Varicella, Mumps, Whooping-Cough, Anthrax, Hydrophobia, Trichinosis, Actinomycosis, Glanders, and Tetanus, James T. Whittaker, M. D.; Air-Passages (Larynx and Bronchi) and Pleura, James C. Wilson; M. D.; Nervous, Muscular, and Mental Diseases (Including Opium Habit, etc), Horatio C. Wood, M. D., and William Osler, M. D.

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ESSENTIALS OF BACTERIOLOGY; Being a Concise and Systematic Introduction of the Study of Micro-Organisms, for the use of Students and Practitioners; By M. V. Ball, M. E. Second edition. Philadelphia: W. B. Saunders. 1893.

¶ Bacteriology has become a recognized essential of a scientific medical education. It is, therefore, imperative that every physician be at least familiar with its principles, if not with the technique. Familiarity with the methods of examination renders otherwise obscure diagnosis comparatively easy and places the physician in a position to render greater service to his patient and the community, by the early recognition of diseases of bacterial origin. There are numerous books which supply such information but none cover the field so completely and concisely as Ball's Essentials of Bacteriology, which is now in its second edition. The first edition published a little over a year ago, has had a flattering reception, and we bespeak the same continued success for this edition. F. P. NORBURY.

DIET FOR THE SICK; By Miss E. Hibbard, Principal of Nurses Training School, Grace Hospital Detroit, and Mrs. Emma Drant, Matron of Michigan College of Medicine Hospital, Detroit; to which has been added Complete Diet Tables for various diseases and conditions, as given by the highest authorities. Detroit, Mich., The Illustrated Medical Journal Co., Publishers. Paper, 74 pages. Price, postpaid, 25 cents; 6 for $1.00.

¶ This little book is a worthy supplement to any cook book, as it deals only with the dishes suitable for the sick and convalescent; the receipts being favorite ones in use daily in the hospitals wherein the authors are employed. To this have been added the various authorized Diet Tables for use in chronic affections of all sorts. It also gives various nutritive enemas. The physician can use it to advantage in explaining his orders for suitable dishes for his patient, leaving the book with the nurse.

The Missouri Medical Directory is now ready for delivery. The most complete list of physicians ever issued in the state. Price, $3.00, post-paid. Address, THE MEDICAL FORTNIGHTLY, St. Louis.

At this time of financial stringency, it is gratifying to see a Southern enterprise, and especially a Southern literary enterprise, give such unmistakable signs of business push and thrift as we find displayed in the August number of *Fetter's Southern Magazine*. Reorganized and now under the editorial management of General Basil W. Duke, whose literary taste and attainments are so widely and favorably known, *Fetter's Southern Magazine* now stands the peer of any in the land. The August number contains an able article upon the famous naturalist, Audubon, revealing the charming and indefatigable genius in a new light. A most opportune essay is the one entitled "Andrew Jackson and the Land Banks," by the Hon. Flourney Rivers, dealing as it does with the wild-cat currency proposed as a remedy for the financial stringency of the early days in Tennessee. The fiction is of a high order. "The Renegade," by Mrs. Sayre, is intensely interesting and dramatic. Other contributors are Opie Read, Robert Burns Wilson, Anna Robinson Watson, Hester Higbee, Angele Crippen, C. Q. Wright, Mary McNeil Scott, and Fani Pusey Gooch.—*Fetter-Bush Publishing Company, Louisville, Kentucky.*

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CLASS-ROOM NOTES.

Never use lead in ulcer of the cornea, as it is apt to produce saturine leucoma.—Michel.

For the insomnia of delirium tremens chloral, carefully, or safer and better, sulphonal may be used.—Bauduy.

You should suspect renal disease when you have, not otherwise easily accounted for, vertigo, hemorrhages, gastric symptoms.—Robinson.

Urea is markedly increased by the use of coffee and tea, hence these should be interdicted in organic and functional derangement of the kidneys. —Curtman.

It is common practice, but bad, nevertheless, to use a solution of sodium chloridum in catarrhal rhinitis. It should be discouraged as it increases the flow from the membrane.—Spencer.

Packing the womb with iodoform gauze, in metritis and subinvolution following labor, accomplishes four needful ends, viz: pressure tending to produce absorption; lessening of blood supply by some cause; drainage and, lastly, antisepsis.—Ford.

My judgment is against the possibility of distinguishing between human and canine blood, except under very favorable circumstances; and those conditions are: 1st, a fresh specimen and, 2d, sufficient in quantity to allow averaging of a large number of results.—Curtman.

In this formidable affection (carbuncle) nature must not be put out of her road by filthy applications, or those which will soon become so, but as such it must be destroyed by the knife, the curette, and strong antiseptics, thereby transforming it into a clean, healthy sore.—Tuholske.

I wish you to understand that you cannot open the belly and handle the viscera without more or less shock. Therefore, it is of the highest degree of propriety to ascertain first, if either one of the two main indications for such a grave procedure exists, viz: hemorrhage, or serious injury to one of the hollow viscera.—Prewitt.

You must remember that, in treating chronic gastritis, regimen is of the first importance. If the patient is given to alcoholics these must be remanded; if to gormandizing this must be stopped, for without such regimen you will do yourself harm and your patient no good. Otherwise you should have nothing to do with the case unless you regard reputation less than *revenue;* science less than *shekels.*—Robinson.

For the very painful affections like epididymitis, Prof. Steer recommends a formula like the following:

℞ Morph. sulph.....gr. i
Chloral hydrat.....℥ iss
Potas. bromid.....℥ ii
Syrup.....℥ iv
Aquæ..... ℥ iiss

M. Sig;—Tablespoonful every three hours, if necessary.

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Prof. Tuholske says that the tincture of cinnamon is an excellent capillary stimulant.

The diet after diphtheria should be non-albuminous for at least one month.—Saunders.

Dr. T. A. Martin recommended liquor potassa for chorea in a boy of sixteen. This failing, resort to liq. pot. arsenitis.

In obstetric practice you should constantly regard infection as coming from without and, therefore, use the greatest cleanliness surgically.—Ford.

The knowledge of the specific gravity of urine is wholly unavailable 'till coupled with that of the amount passed in twenty-four hours.—Curtman.

As a headache powder in the various forms of meningitis, Prof. Bauduy recommends the combination of phenacetin and citrate of caffeine in the proportion of 4:1 respectively.

When you find nothing to do but purge your patient, do nothing. There is more harm done by catharsis than constipation. Of course, there are exceptions to this, but that does not invalidate the rule.—Michel.

In complete intestinal obstruction there may be one action after it has occurred, due to increased peristalsis below the point of obstruction. After this nothing passes; otherwise it is not complete obstruction.—Prewitt.

If I were limited to the use of a single remedy in the treatment of diphtheria, I would unhesitatingly choose alcohol in some one of its forms, as I've seen more good come of its use in this affection than of any I ever tried.—Robinson.

The treatment of tumors is, indeed, a very barren subject, when you eliminate the knife. In reviewing the subject the knife is the only thing of real value in the light of our present knowledge. There are probably one or two exceptions, viz: arsenic, internally in lymphoma (Hodgkin's disease); position, rest, electricity, ergot, in arresting the growth of, and in some instances causing retrogressive changes in the so-called "arterine fibroid." —Tuholske.

To allay the irritable cough in phthisis the following possesses considerable merit:

℞ Acidi hydrocyanici diluti.....ʒ i
Syrupi pruni Virginianæ.....ʒ iii
Morphinæ sulphatis.....gr. ii

Sig:—Teaspoonful every two or three hours.—Steer.

As a general tonic in endometritis:

℞ Magnesii sulphatis.....ʒ ii
Ferri sulphatis.....grs. xvi
Acidi sulphurici diluti.....ʒ i
Aquæ.....O i

Sig:—Tablespoonful in water before meals.—Engelmann.

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Society Proceedings.

(OFFICIAL)

ST. LOUIS MEDICAL SOCIETY.

[STENOGRAPHICALLY REPORTED FOR THE MEDICAL FORTNIGHTLY]

GEO. E. ALVORD, M. D., Editor.

Stated meeting, Saturday evening, April 22d, 1893; The President, A. B. Shaw, M. D., in the chair.

DR. L. M. PERKINS read a paper on **Malarial Hematuria.** (See page 456.)

DR. L. T. RIESMEYER said it was possible that the hematuria might be due to malaria, but he thought there was hardly sufficient proof of it. It would be extremely important to examine the blood for the plasmodium malariæ. If it were malarial in origin it should yield to quinine, but it had not done so.

DR. G. W. BROOME did not think there was constitutional trouble enough to warrant a diagnosis of bleeding from the kidneys. He saw a patient recently with papilloma of the bladder in which there was occasional bleeding. In this case, also, the blood was not clotted.

Stated meeting, Saturday evening, May 20th, 1893; The President, A. B. Shaw, M. D., in the chair.

DR. HEINE MARKS presented a **Tumor of the Pons Varolii,** giving the following history of the case: L. E., colored, hostler, 24 years of age, admitted to the City Hospital May 15th, 1893. So far as known, his family history was good. He had had gonorrhœa five years ago, and chancroid one year later. Was addicted to the use of alcohol. On December 25th, 1892, patient was struck with a brick over left supra-orbital ridge, after which he complained continually of headache. Two months after accident his right arm, and subsequently his right leg, became paralyzed. When admitted to the hospital he was much emaciated and semi-conscious. Examination revealed paralysis of right arm and leg, anæsthesia on left side, reflexes incurred, facial paralysis on left side, and an ulcer of the cornea of left eye, presumably due to his inability to close it. He died on May 18th. Post-mortem examination revealed congestion of the brain and meninges. Near the upper and anterior part of the pons, in the median line, was a firm circumscribed tumor, about the size of a large marble. On cutting through the tumor its internal portion was granular, as though made up of miliary tubercles and of a grayish color.

DR. J. W. SMITH presented a **Placenta** which he had removed from a patient to whom he was called by the midwife in attendance. The patient was delivered after she had been in labor for two days and nights, but the midwife could not get the placenta away, and on examination the doctor found that it was adherent to a growth as large as his fist, which he concluded was a fibroid tumor. He hardly knew at the time whether he would

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be justified in removing this tumor or not, but concluded not to attempt it. He succeeded in tearing the placenta away from the growth. Quite an extent of exposed surface was left, and he thought afterwards that perhaps it would have been as well to have removed the tumor at the same time. He asked for an expression of opinion on the subject.

DR. H. W. HERMANN said that he had had an opportunity to see the case to which Dr. Marks referred, about a week before. The man was delirious at the time, and his answers were not, therefore, very reliable. The facial paralysis on the left side was very marked. There was also, as Dr. Marks had stated, ulceration of the cornea on the left side. The motion of the left eye was also interfered with, particularly adduction. There was no anæsthesia in the region of the trigeminus on the left side. An interesting question was, whether the ulceration of the cornea was due to involvement of the trophii fibres of the trigeminus, or to irritation from foreign bodies, the result of the patient's inability to close the eye. He had seen a great many cases of Bell's palsy where the eye could not be closed, but he never saw an ulceration of the cornea merely from that cause. He was inclined to think there were trophic changes or disturbances. The patellar on the right side were exaggerated more than on the left. That would point to trouble in or about the pons. It was exceedingly difficult to examine the patient on account of his delirium. Replying to a question by Dr. Barck he said that it was difficult to determine the sensibility, but he did not think there was decided anæsthesia on the right side of the body, and he was sure there was none on the left.

DR. F. R. FRY inquired if a tuberculous history had been made out prior to the patient's death, and was informed by Dr. Marks that it had.

DR. C. BARCK said it would seem from the history that the growth was located on the left side, but the reports were somewhat conflicting. If he understood Dr. Marks correctly, the right side was completely paralyzed, and Dr. Hermann stated that there was a paretic condition of both sides. These conditions of the pons are interesting because the question of the crossing of the motor fibres is not fully settled as yet, and as the anatomists had not settled the question as to the crossing of the fibres in the optic chiasm, it was probable that the matter must be determined by clinical tests.

DR. FRY said that the conclusions of Dr. Hermann, viz. that there was facial paralysis on the left side, and that the paresis of the extremeties was more marked on the right side, were in accord with what is generally observed in cases of lesions involving the pons. The remarkable thing to him was that there should not have been more paralysis in such a large involvement of one side of the pons as was indicated by the appearance of the specimen. On the right side, it seemed to him that the tumor possibly did not extend far enough to involve the region of the pyramid, but on the left it would seem that all these fibres were implicated. This case illustrated a point which should be borne in mind, that we should not too quickly jump at a conclusion where there is a history of traumatism. This had been impressed upon his mind a number of times. This man received a blow upon the head, and two months afterwards there were evidences of

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paralysis, but there was no evidence that the traumatism had anything to do with the trouble. A few years age he showed to the society a little tumor which had been removed post-mortem from the brain of an epileptic. It was situated immediately beneath the pons. This patient had fallen from a second story window, when fifteen years old, and struck upon the back of his head. Two months afterwards he began to have epileptic sprsms. The trauma was believed to be the cause of the epilepsy, and he was trephined at the site of injury. Although it could not be stated positively that the tumor was the cause of the epilepsy, yet it was a more probable cause than the trauma, because on post-mortem examination there was found to be nothing the matter with the brain at the site of the trephine operation.

DR. H. C. DALTON, referring to Dr. Smith's case, thought that doctor did well to let the tumor alone. The patient's life was certainly endangered, and the growth could easily be removed at some future time.

DR. HURT inquired if there was fixation of the uterus.

DR. SMITH replied that it was freely movable.

DR. HURT said the case recalled to his mind one he saw some years ago. The patient, a primipara, had a tedious labor, and there was retention of the placenta. He worked with the case for several hours and finally passed his hand into the uterus and found that the placenta was adherent to a tumor that seemed to be opposite the right sacro-iliac synchondrosis, and the uterus was firmly fixed on that side. The patient made a good recovery, and he lost sight of her. So far as he knew the tumor, which seemed to be a fibroid, was never removed.

DR. S. POLLAK reported a case of **"Ophthalmia Albuminurica,"** (published in full in *American Journal of Ophthalmology*, May, 1893). A girl, aged seven years, after a slight exposure to the cold, was taken sick, the symptoms being vague and indefinite. The third day she was restless, had some fever and cough, and complained that everything "looked red." The family physician was summoned, and saw her for several days. On January 2d (eight days after the beginning of the attack) Dr. Pollack was called in consultation on account of the serious condition of her eyes. The patient complained of great thirst, had no appetite, bowels constipated, abdomen not tender, urine scanty, skin dry. The eyelids looked normal. When they were separated the globes were found to be chalky white, resembling nothing so much as the opening ball of the cotton plant. The cornea and sclera were alike white, a slight palish of the sclera making the only difference. No blood vessels were seen, conjunctiva not chemosed, ball rather anæsthetic. No trace of the iris to be seen. The anterior chamber seemed to be filled with a white homogenous substance, whether fluid or semi-solid could not be determined, neither was it certain that the pænchyma of the cornea was not involved. Motion of the eye was unaffected, but there was not the least perception of light. While in doubt as to the diagnosis, something had to be done, and he ordered hot applications locally, and a tropine instilled into the eye. Internally, calomel, gr. 1-10 every hour. Two days later some urine was secured and found to contain albumin in large quantities. He inferred from the condition of the urine

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that the exposure to the cold had "caused an acute nephritis and general albuminuria, which by metastasis found a suitable soil in the eye, saturated strongly the agneous humor, and perhaps made deposits of albumin in the tissues of the eye." Diuretics were given, and her general condition improved, but it was not until the tenth day of his attendance that he noticed any change in the eyes. The right eye then began to clear, starting from the center, followed in a day or two by the other eye. In about two weeks both corneas were clear and the pupils dilated, but there was no perception of light. Her general health improved, and the albuminuria subsided. The condition of the eyes remained stationary up to February 10th, when pure ophthalmitis of the right eye set in, and it had to be removed. The patient is now totally blind, with a cataractous lens, distorted pupil, and posterior synechia of the left eye.

DR. A. ALT reported on the histological examination of the eye removed by Dr. Pollack (See *Am. Jour. Ophthalmology*, May, 1893). When he first saw the case with Dr. Pollack the white, chalky appearance of the eyeball, upon which the doctor based its clinical name, had disappeared. There was general inflammation of the eyeball, with increased tension. The right eye was removed and hardened in Mueller's fluid. "When the eyeball was opened no tumor presented, and what appeared to be behind the lens was seen to be the totally detached retina, firmly united with cyclitis nerve functions. The posterior chamber was totally obliterated; that portion of the anterior chamber which corresponds to the iris angle was filled with a uniformly transparent gelatinous substance, while in the pupillary area the lens lay close to the cornea and obliterated this portion of the anterior cnamber. The space between the solid strand of the detached retinal tissue, which ran from the optic nerve forward to the cystitic membrane, and the swollen chronoid, and also the supra-choroidal space, were filled with congested exudation. Upon the inner surface of the choroid yellowish masses were deposited in thick layers and in smaller lumps. These masses were thicker near the ciliary body than in the posterior portions. "The conclusion he arrived at, from the macroscopal and microscopical appearance of the eye examined, was that the clinical features of case, as described by Dr. Pollack, were produced "by spongy (croupous) exudation in both anterior chambers, due to *croupous irido-choroiditis*." From the subsequent bacteriological examinations by Dr. Riesmeyer it would seem that the croupous nephritis and the croupous irido-choroiditis were pephaps both due to the same microbe, which in the eye resembled most the staphylococcus pyogenes arereus.

DR. WOLFNER also saw Dr. Pollak's case after the chalky whiteness had disappeared. Were it not for the peculiar history he would take it for an ordinary case of purulent irido-choroiditis, so frequently found metastaltic after cerebro-spinal meningitis. Since seeing Dr. Pollak's case he had seen four other cases, in three of which both eyes were lost, and in the fourth only one. The oldest patient was only seventeen; the youngest, two and one-half years. All of these lost their sight within twenty-four hours, and the history was almost similar in every case. The patient was taken sick, had high fever, and the next day complained of soreness about

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the joints with some swelling, which soon subsided. In all of them the eye eye trouble was discovered by accident. The patients seemed indifferent, and until the inception of the eye trouble there was no affection of the vision. Winter before last he saw a case of metastatic irido-choroiditis in connection with an attack of grippe. He had not seen a single case of this character not metastatic, usually in connection with cerebro-spinal meningitis. He saw other cases of grippe blindness, winter before last, due to inflammation of the optic nerve.

DR. C. BARCK freely agreed with Drs. Alt and Wolfner that there could be hardly any doubt that the case was one of metastatic irido-choroiditis, even judging from the history alone. He believed Dr. Pollak's theory as the cause of the trouble would hardly be sustained. There is no case on record where the introduction of albumen into the tissues of the eye caused such a trouble. Besides, these cases seemed to have been very frequent during the past winter. He had seen several cases where both eyes became entirely blind. There was hardly any doubt that the case reported was due to some kind of infectious disease. He would like to inquire if there were any symptoms of cerebro-spinal meningitis or convulsions?

DR. POLLAK said there were absolutely none.

DR. DICKINSON thought that Dr. Pollak's views were correct, that the white appearance of the eye was caused by the deposition of albumen in its structures.

DR. A. D. WILLIAMS inquired if there was much hemorrhage when the eye was enucleated, and was informed by Dr. Pollack that there was not. He regarded the case as one of simple iridi-choroiditis with extensive exudation of lymph, the exudation being not only into the eye, but also into the tissue back of the eye. This would account for the protrusion of the eye referred to, and also the slight hemorrhage encountered in removing it. It was probably the result of some acute infection of the blood, of just what nature would be difficult to say.

DR. WM. O. LANGAN said the case reported was of peculiar interest to him because he had had two similar cases last winter. Both cases presented symptoms of acute cerebro-spinal meningitis, followed in a few days by pains simulating acute rheumatism, with photophobia, and a white, chalky appearance of the eyeball.

DR. BARCK inquired if the prognosis was absolutely hopeless. He had read of some cases treated in the beginning with mercury, and blindness had been prevented in some of them.

DR. LANGAN said that in his cases the oleate of mercury had been given to salivation, but without effect.

DR. POLLAK thought that all the gentlemen explained very satisfactorily the condition of the eyes as they saw it in the second stage, but it was not so easy to explain the condition as it existed at first. There was no swelling of the eye and no pain. There was no fever and no inflammation. His inference that the trouble was due to albuminuria might be wrong, but he knew no other way to explain it.

DR. C. BARCK read a paper on **"Tattooing of Corneal Cicatrices,"** exhibiting an instrument devised by himself for that purpose. (See p. 455.)

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The Pan-Amerian Congress.—For the meeting of the Pan-American Medical Congress to be held in Washington, D. C., beginning September 5th, The Ohio & Mississippi Railway offers a through train service which is not equalled by any other line. It is, properly speaking, the only direct through car line from the Mississippi River to Washington. Our morning and evening trains leaving St. Louis daily, run through to Washington via the picturesque Baltimore & Ohio route, with Pullman Vestibule Buffet Sleeping coaches, delivering passengers in Washington at seasonable hours and in advance of all competitors. No other line affords a double daily sleeping car service between St. Louis and Washington. Delegates and others attending the Medical Congress will be furnished full information as the reduced rate, etc., on application to G. B. Warfel, General Western Passenger Agent, at the City Office, 105 North Broadway, St. Louis, Mo.

Neuralgia.—Neuralgia, or neural hyperæsthesia, is the generic name for a number of diseases of which the chief symptom is pain following the course of a nerve or group of nerves and generally fixing itself where the nerve emerges from a foramen or at a superficial point just before it dips into a fascia. This designation is indefinite and leaves room for many central lesions to be classed as neuralgia, which have an entirely different pathology, and consequently require different treatment. No pain that is due to a disease of the brain or spinal cord should be called neuralgia, but that alone which is limited to a nerve in some part of its course.

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I have used cactina pillets and find them very valuable in common heart troubles when weakness and irregular action is manifested. I shall use them in the future. ALBERT DAY, M. D., Superintendent and Physician of Washingtonian Home. Boston, Mass.

I have found Peacock's bromides exceedingly efficacious in headache and cerebral congestion, more so by far than the ordinary bromides. JAMES MACMUNN, L. R. C. P., L. R. C. S., Resident Medical Officer Great Northern Hospital, London. 39 Cecile Park, Crouch End, London, Eng.

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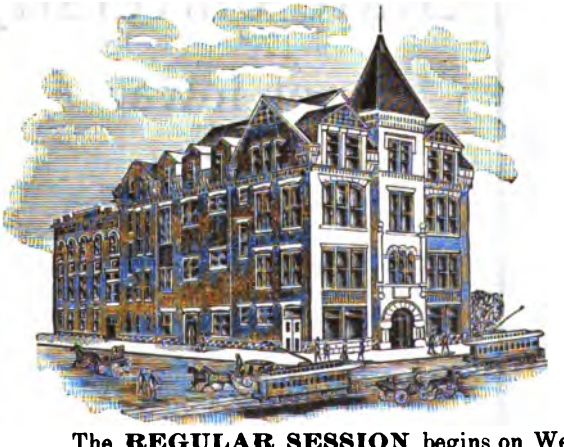

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Fig. I—Normal.

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Fig. IX—Chloroform Position.

Fig. XVII—Dorsal.

A few of the positions are: normal, reclining, semi-reclining, horizontal, ¾ length, dorsal, Sim's, right or left lateral oblique, dorsal with hips raised, side tilt, raising or lowering, chloroform narcosis, rotating, etc.

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# of Manufacturing

a few figs are used, but to distinguish it from all other laxatives, and the United States Courts have decided that we have the exclusive right to apply this name to a laxative medicine. The dose of

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as a laxative is one or two teaspoonfuls given preferably before breakfast or at bed time. From one-half to one tablespoonful acts as a purgative, and may be repeated in six hours if necessary.

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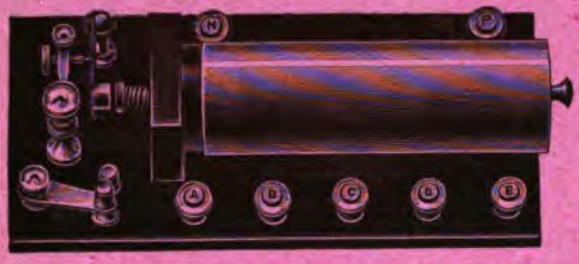

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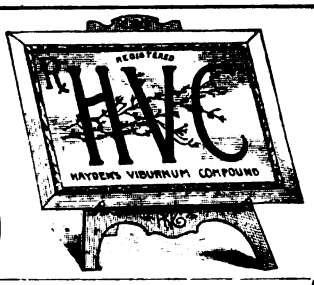

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